Mandatory Case Planning for Minnesota Minor Mothers and Their Children

A Report on Implementing Minnesota Statutues 1988, Section 257.33*

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December 1989

*Incorporated in 1987, Chapter 403, article 3, subdivision 44, known as the Welfare Reform Package

This research report has been funded by the Center for Urban and Regional Affairs, University of Minnesota, 330 Hubert Humphrey Center, 301 19th Avenue S., Minneapolis, MN 55455.

ACKNOWLEDGEMENTS

There are a many people to thank for their help and support in producing this study on an important piece of legislation affecting the lives of minor parents and their children in Minnesota.

We acknowledge, with gratitude, the valuable help and encouragement of Mabel Huber, Minnesota Department of Human Services, and Barbara McBain, a former staff member of Minnesota Department of Health and Human Services, Division of Children's Services. They were not only receptive to the idea of a survey, but gave time and attention to the construction of the questionnaire and its revisions and provided technical assistance in communicating with the 87 counties in the state. Further, Mabel Huber maintained a close interest in seeing the project come to a successful conclusion. She was always cheerfully available for consultation.

In addition, crucial funding and support was provided by the Center for Urban and Regional Affairs, University of Minnesota.

This study was fortunate to have two outstanding graduate students in the School of Social Work as research assistants. Mary Ford and Sue Keskinen made an indispensable contribution in data gathering and data analysis. Further, in conducting the telephone interviews, they provided questions and comments that enriched the study in important ways. Mary Ford continued to work on the project through its final phase, providing excellent written summaries of particular responses to the questions in the survey.

This study could not have been accomplished without the cooperation of the key informants of this survey who took the time and energy to retrieve information for the report. These were chiefly front-line workers and their supervisors in county human service departments where the struggle for

implementation of statutory requirements takes place. We deeply appreciate their efforts and their commitment to improve services to minor mothers.

Finally, a large measure of thanks to Mary Kaye Weller, who provided more than outstanding secretarial help. Her unflagging good humor through revisions of the questionnaire and final drafts of the study are very much appreciated.

The interpretative content and opinions expressed in this paper are solely the responsibility of the author and do not necessarily reflect those of the Minnesota Department of Human Services.

Highlights of the Study on the Mandatory Requirementof Social Service Involvement of Minor Parents and Their Children

Eighty-two of 87 counties participated in this survey conducted by telephone interviews with 53 front-line workers and 24 supervisors in county social service agencies. The legislation directing county social services to develop a case plan containing 11 items for every minor mother age 17 and under was passed in August, 1987. These interviews were conducted in October and November, 1988.

Coordination of Agencies

- 20% of counties report good collaboration on plans among social services workers, financial workers, and the collateral agencies of schools and public health.
- A small percent (13 counties) reported that the social service worker and public health nurse do the case planning together, in joint home visits.
- 45% (37 counties) explore "collateral contacts," (public health nurses, school social workers, family members) for additional information for the case plan, in order to gain a clear assessment of the minor mother and her needs.
- The financial worker in 41% of the counties is assigned to check on school attendance.
- Large urbanized counties report tracking problems due to moblity, unexplained absences, and the random events that disrupt the maintenance of continuous school attendance.

Procedures

- Most counties respond within 5-7 days after receiving the 72-hour hospital notice of a birth to a minor mother.
- Almost 80% of county social services use a home visit as a vehicle for developing the case plan.

Approaches to the Minor Mother

- 73% of the counties refer to the mandatory nature of the statute as the rationale for the contact.
- 5 counties reported that they interpret the statute as referring only to minor mothers on AFDC.
- A small number of counties made unannounced visits.
- Letters introducing the case plan requirement varied in tone and substance from a friendly introduction and offer of services to a sterm warning on sanctions for failure to comply.
- 22% (385 mothers) have independently produced their own case management plan.
- 10 counties report a refusal to participate in case planning because this legislation is considered an invasion of privacy.

Developing the Case Plan

- A wide range of assessment forms are used, ranging from a routine checklist to an assessment form designed to lay out specific expectations of behavior with concrete goals and objectives.
- 67% of the counties use the mandated 11-point requirements as a checklist, in a face-to-face interview.
- 30% of the counties have developed their own forms.
- Scattered counties use an assessment form developed for public health nurses.

- Almost all counties reported that the assessment is shown to and occasionally signed by the minor mother, implying that the development of the plan is a cooperative enterprise.
- 25% of counties recommended adding chemical dependency, counselling, and family planning as separate items for the case plan.

Sources of Referral and the Discovery of New Cases

- A total of 1,755 births to minor mothers since the inception of this legislation have been brought to the attention of the counties. Out of those births to minor mothers, 40% were already active in the agency, prior to the 72-hour notice. Of these, 44% of the counties received referrals from schools, while the mother was still pregnant, indicating that good communication exists in these counties between the school systems and county social services.
- Generally, public health nurses, the schools, and income maintenance workers are the chief sources of referral, for most counties.
- Almost 60% perceive the legislation as mandating the opening of a file.
- Twenty counties, less than a third, reported that they opened a file at intake and kept it open, with the intention of keeping it open until the mother turns 18.
- A small percentage of counties report that they opened a file only when they are concerned about the "failure to thrive" condition of the infant and when they suspect that there might be a potential referral to child protection. The amount of paperwork in opening a case often leads some counties to use an information and referral or slight services mode which means that they can still explore the need for services without the formal opening of a case that entails a good deal of paperwork.
- A uniform policy or set of criteria for opening a case does not exist.

- Fifty-five counties reported no record of referral of minor mothers to child protection services. A large major urban county reported that the rate of referral to child protection was 13%. However, in another urban county, out of 300 active cases, only 2%, i.e., six cases were referred to child protection.
- Approximately 6% of the cases without a previous contact are referred immediately to protective services. Approximately nine percent of the cases (approximately 113 minor mothers) are referred for long-term supervision.
- Assessing the adequacy of living arrangements, conflicts with grandparents on child rearing practices, and mobility are described as problems.
- The AFDC grant is widely reported as insufficient for basic income.
- Some counties routinely required attendance at parenting classes. Forty-five percent consult with other professionals to assist in assessing parenting skills.
- 70% of county social service workers reported that assessing parenting skills of the minor mothers was the most difficult part of the plan.
- Problems in carrying out the legislation:

  -- lack of available child care
  -- lack of transportation
  -- inconsistent reporting by hospitals
  -- lack of alternative educational resources
  -- lack of training and knowledge in assessing parenting skills

- Generally, the non-AFDC minor mother had better support networks of family and friends than did AFDC minor mothers.
- 9% of minor mothers are involved in groups exploring adoption decisions.
- Living arrangements are volatile. At the time of the interview, 53% of minor mothers were living with their parents, 33% in independent households, and the remainder in transitional housing.

- 20% of the counties refrain from any discussion of family planning.
- 83% report giving the minor mother the "Tennesen Warning." A written statement is handed out. A specifically designed piece for minor mothers was not identified in any county.
- Approximately 66% of minor mothers are perceived to need the following services: WIC; family planning; housing; legal aid; counselling.
- One-third of counties report no attempt to involve the father. Two-thirds report extending the offer of services through the mother, but no direct counselling. More than half make a direct referral to the Office of Child Support Enforcement (IV-D).
- 13 counties report a referral of the father to parenting classes.
- An assessment of the father's role is identified as difficult in a majority of counties.
- A significant majority (65% of the counties) say they do not assist the mother in signing a Declaration of Parentage.

Observations

- The social service workers generally approve of this legislation; they find that it clarifies their role and has made their work more effective. But this has a cost. A significant number (35%) found that the legislation has added a burden to an already overburdened staff. They were already engaged in child protection, foster home placement, custody studies, and responding to families and children in need of services.
- There are wide variations in planning for systematic reviews of the case plan.
- A surprisingly small number of "high risk" minor mothers turned up. This might reflect the fact that the interviews took place in a "honeymoon period," within a week or two of the birth of the baby, when support

networks are still in place. This early interview time might mask problems which will erupt later. 40% of the minor mothers assessed statewide were already known to county human services. Overall, 15% of the cases were judged to be at high risk: to be carried for long-term supervision or referred to child protection. Further, 15% of counties reported that they have been offering these services all along, most often in cooperation with school programs that have active programs for responding to pregnant and parenting teenagers.

- These are needed services that are frequently unavailable:

  -- child care
  -- transportation
  -- housing
  -- legal aid
  -- remedial education
  -- counselling
  -- income supplement

Follow-up Plans

- Follow-up plans, as revealed in the interview data, are loose and often poorly defined. A small portion, 18%, routinely keep the case open until 18. Systematic and routine follow-up at regular intervals is not a general pattern.
- The role of the social service worker is clearly problematical. There was uncertainty as to whether the social service worker should present him or herself as "an agent" of the state: carrying out of surveillance for a legislative mandate; or whether the worker identifies the role as one of advocacy for the minor mother and her child; or as a case manager to scrounge resources. Generally, social service workers prefer to think of themselves as case managers who do all of the above.
- Less than 5% of the minor mothers are considered "eager and interested" in participating in the process of developing a case plan.

- Various discriminatory patterns were identified in issues of gender, age, and economic status: the lack of father's involvement in a case plan; the lack of sanctions for non-compliance of a non-AFDC mother in a school plan; the cut-off in the age of the minor mother at 17, when many high risk situations develop at a later age; the ineligibility for various services of minor mothers living in low-income, working families.
- In a small number of counties, the legislation was questioned on grounds that it might violate the rights of minors to privacy.
- Issues dealing with cultural diversity and ethnicity are also raised. Fourteen counties reported outreach difficulties with Native American and migrant minor mothers because of mobility and "unavailability." The interaction with the Indian Child Welfare system is not clear.
- Hospital reports are not always made within the mandated 72 hours following the birth to a minor mother. There appear to be some problems with late and selective reports from hospitals in suburban areas and those in the outlying areas.
- Remediation resources for school failure or difficulty are very sparse.

Recommendations

- Training in child development and observational skills in assessing parent-child interactions is the most urgent training need.
- Training to clarify the intent of the legislative statute and translating this intent into procedures for case opening and follow-up, with some guidelines, should be initiated.
- Services to increase the involvement of the father with particular reference to the paternity adjudication issue requires focused attention.

- The development of small support groups for minor parents to exchange information, solve mutual problems, and provide a break in the isolation of young, unmarried parents should be encouraged.
- Exchanges with county social service staff in the same region should be initiated. These peer review opportunities should be scheduled regularly for assessing implementation issues in the legislation. Recommendations should be forwarded to supervisors and adminstrators and responses should be circulated.
- The state should assist counties in the preparation of wasy to read information and referral brochures; a single translation of the Tennesen warning; a clearly stated pamphlet on paternity adjudication and benefits to the child associated with a paternity action.
- A survey of the attitudes of minor mothers on their experiences with this legislation would be helpful.

Conclusion

Mandatory case planning tests the legislative intent to initiate a preventive strategy. The Minnesota Statute plunges the state into the complex and perplexing arena of balancing the right of the state to intervene in the best interests of the minor mother and her child, and the right of minor mothers to protect their privacy until harm has been demonstrated.

What this survey provides is an identification of issues to be explored and base data from which to do follow-up. The extent to which this legislation works to enhance the life chances for minor mothers and their children is yet to be studied.

Report on Research Project on Mandatory Case Planning for Minor Mothers and Their Children

BACKGROUND

The 1987 Minnesota Legislature amended an existing statute[1] providing for the "offer" of social services to minor parents and their children, and thereby outlined, in some detail, a requirement for every minor mother in the state to have a plan for herself and her child.

The amended legislation directs county social services agencies to contact every minor mother, upon receiving a "72-hour report of birth to a minor" from the hospital where the birth occurred. Every minor mother who does not have a case manager must now have a plan for herself and her child. The legislation defines what the plan must consider:

1. the age of the minor parent;
2. the involvement of the minor's parents or of other adults who provide active, ongoing guidance, support, and supervision;
3. the involvement of the father of the minor's child, including steps being taken to establish paternity, if appropriate;
4. a decision of the minor to keep and raise her child or place the child for adoption;
5. completion of high school or GED;
6. current economic support of the minor parent and child and plans for economic self-sufficiency;
7. parenting skills of the minor parent;
8. living arrangements of the minor parent and child;
9. child care and transportation needed for education, training, or employment;

10. ongoing health care; and

11. other services as needed to address personal or family problems or to facilitate the personal growth and development and economic self-sufficiency of the minor parent and child.

Further, county social services are directed to open a social services case, for each minor parent who does not have a case manager, with a case record that should contain the plan for the minor mother and documentation of the appropriate follow-through in the situation.[2]

The county social services agencies, moreover, are instructed to take "appropriate" steps if the minor parent refuses to plan for herself and her child or fails, without good cause,[3] to follow through on an agreed-upon plan. The county social services agency may request that a petition be filed to place the mother and child under "protective supervision,"[4] or institute a protective payment[5] on the grounds that the minor parent's child is dependent due to the state of immaturity of the minor parent.

All minor mothers, married or unmarried, on AFDC or non-AFDC, who have not reached their 18th birthday come under the jurisdiction of this legislation.

This legislation, sometimes known as "mandatory services to minor mothers," became effective on August 1, 1987.

There is no available written record of testimony or discussion on this statute. However, it is clear from exchanges with Senate counsel staff and legislators that growing concerns about minor parents and their children motivated the change from an "offer" of services to the substance of the Minnesota statute of 1987, a mandate requiring compliance with a case plan.

Foremost among the concerns of elected officials and others were the findings of a Minnesota study[6] (confirming national studies) that minor

mothers were at high risk for long-term welfare recipiency. Further, discussions were occurring in several different legislative committees about a range of problems associated with minor mothers focusing on their immaturity and lack of resources for the financial and emotional well-being of their children.

At the same time, a number of legislators expressed interest in exploring ways to change the AFDC program to require teenage parents to attend high school and to require social services involvement. However, they were advised that this would require a federal waiver which would be slow in coming and uncertain in outcome.

There was also pressure in the legislative session to raise the grant level of AFDC. An alternative, providing social services to prevent welfare dependency, seemed to be a reasonable response given the harsh financial constraints of the state budget. Anecdotal data that teenagers were increasingly caring for their infants in questionable living arrangements reinforced the motivation to require a case plan for every minor mother, if she did not already have a case plan in place.

In a subcommittee hearing on welfare reform, the idea originated that the compulsory school attendance of the welfare reform bill could be broadened to include issues of housing and social services.[7] It was also suggested that the use of the Juvenile Court Act (sections 260.011 to 260.301) would give the legislation "teeth" since the courts already had the authority to intervene in cases where a child needs supervision because of the immaturity of the parent.

The intent was clear: to link the teen mother with a variety of services including parenting skills, health care, transportation and child care, and possibly referral for social services, such as counselling.

Further, the legislation was intended to provide county social services agencies with the authority to monitor and supervise the minor mothers,

assuming a case management role, and to enforce conditions in the event of non-compliance.

This legislation was conceived as a preventive strategy.

The mandatory nature of the bill and the proposed enforcement measures were not without controversy. A decision was made in the subcommittee on welfare reform to amend the Juvenile Code to relate it specifically to the case of minor parents, in order to authorize the court to order protective supervision for dependent children of minor parents for non-compliance with the case plan.[8] The Judiciary Committee, however, in reviewing the legislation, raised questions based on the constitutional guarantee of "equal protection," and eliminated the Juvenile Code amendment. Moreover, the Judiciary Committee was reluctant to permit the use of the enforcement section of the Juvenile Code for purposes of securing compliance with the case planning provisions, suggesting that this over-stretched the original purpose of the code. It was made known that if county social services agencies used the enforcement section, they would have to assume a burden of proof that could stand up to judicial scrutiny. The legislation was finally approved in a House and Senate conference committee.

A decision was made not to submit the legislation as a separate bill, but, in fact, to sandwich it within the complicated welfare reform legislation. The statute became part of the 1987 welfare reform legislation.[9]

The Survey

In order to explore how this legislation was implemented among the counties in Minnesota, a questionnaire was constructed with the assistance of Mabel Huber, Minnesota Department of Human Services, Barbara McBain, a former staff member of Human Services, and two graduate students in the School of Social Work, Mary Ford and Sue Keskinen. The students conducted the survey in

telephone interviews. Each interview lasted from 45 minutes to over an hour. The respondents were chiefly front-line workers (53) and supervisors (24). A few directors (5) and middle managers also participated. The front-line workers were chiefly female. Confidentiality was assured.

Eighty-two of 87 counties participated in this survey. Two counties had no record of minor births. (See Appendix 1 for a county distribution of births to minor mothers.)

Approximately 1,775 minor mothers have been served since this legislation was finalized in August, 1987. Counties implemented the statute at various times within the first six months of that date. The interviews took place in March, April and May, 1989.

It should be noted that the data was gathered in one-time telephone interviews. The data, then, must be treated with caution, since changes in procedures and adaptations to the legislation occurred at frequent intervals. However, this "snapshot" provides a "state of the art" statement of the first year of the legislation's implementation.

FINDINGS

Coordination of Agencies

Collaborative relationships with public health, the schools, income maintenance, mental health, and other community agencies are required if a comprehensive plan is to be developed. How effective are these collaborative relationships?

The findings suggest that the size of the county is a determining factor in this. Twenty percent of the counties recorded good coordination among social services workers, financial workers, and the collateral agencies of schools and public health. In a small percentage (13 counties), the social worker and public health nurse do the case planning together in joint home

visits. In some of these instances, the public health nurse, according to respondents, softens the presence of the county social service worker who is often perceived as intimidating and threatening because of their association with child protection issues.

Thirty-seven counties (or 45%) explore "collateral contacts" (public health nurses, school social workers, family members) for additional information for the case plan, in order to gain a clearer assessment of the minor mother and her needs.

Typically, it is the small and mid-size counties where collaborative contacts are maintained.

The crucial requirement of school attendance follow-up is most often assigned to the financial worker (41% of the counties) who checks on school attendance at regular intervals. In over a third of the counties, the social service worker is the school monitor. For the remainder, reporting responsibilities are undergoing changes. In small and mid-size counties, social workers, financial workers, and school officials communicate easily and informally on the status of the minor mother's school attendance and other issues. The information is not as easily or as frequently exchanged in very large counties. Large urbanized counties report tracking problems due to mobility, unexplained absences, and the random events that disrupt the maintenance of continuous school attendance. Whether or not these circumstances should initiate a sanction is identified as a potential source of conflict among three concerned units--the school, AFDC, and the social services unit.

Procedures

After receiving the 72-hour hospital notice, social service workers generally respond in a timely fashion. In most counties, not more than five to seven days elapse before a minor mother is contacted. In large counties, the contact also occurs quickly, most often within a few days.

Forty-one percent of counties make the initial contact with the minor mother by phone, 31% by letter, 22% by letter and phone, and 6% in a variety of ways.

A "home visit" is the dominant method of assessment. Almost 80% of the counties, including large counties, use a home visit as a vehicle for developing the case plan. In rural areas, rather typically, the mother is contacted directly by a home visit, since access to phones is difficult and mail contact is not considered an effective outreach strategy.

Tracking down minor mothers, a percentage of whom are highly mobile, is an issue for 20 of the counties. Typically, one to two weeks is spent in an effort to locate the mother.

Approaches to the Minor Mother

In introducing themselves to the minor mother, almost 73% of the counties refer to the mandatory nature of the statute as the rationale for the contact. However, 27% prefer to present the case plan development as a voluntary arrangement and one that is in the framework of "offering services."

Five counties reported that they interpret the statute as referring only to minor mothers on AFDC.

Most county social services workers schedule appointment with minor mothers to discuss their case plans. A few social service workers visit the minor mothers while they are still in the hospital. However, a small number of counties make unannounced visits and lean very heavily on the mandated

requirement and the sanctions associated with this legislation.

A small number of copies of letters introducing county social service workers were received for purposes of this survey. Wide variations in tone and substance were revealed, ranging from friendly (congratulations on the birth) and an "offer" of services, to a stern warning of consequences for failure to comply. Follow-up letters for failure to contact the agency threatened the mother with protective supervision and "changes" in her AFDC grant.

The following responses reveal the varieties of ways in which the social services worker presents him or herself:

> "We inform them that the mandate is to make sure that they have healthy babies. We say, These are your services. We are not here to take your baby away. We also have extensive outreach programs to teen parents and pregnant teens which give them information on child support, adoption, social information, etc. So with all of these services, we really don't have to threaten with statutes."
>
> "The mandate provides social workers with something concrete to work with. Social worker is no longer seen as an ogre, because it's now a state imposed law."
>
> "I identify myself. I tell them why I am calling. Very often I do a telephone interview. People don't tell me to jump in the lake, which is a surprise. There are no refusals. If we don't get them by phone, we send a note and ask them to call."

However, scattered reports of resistance to the assessment are noted.

In ten counties, both the mothers and their parents have stated, outright, that this legislation is an invasion of their privacy. One social service worker commented, "I have had three mothers who are not on AFDC refuse to see me. But I talk to them on the phone, and I tell them of the available services."

Twenty-two percent (385) of minor mothers have independently produced their own case management plan. This appears to be satisfactory to the social

service worker, i.e., the minor mother satisfactorily answered questions in the 11-point plan.

Developing the Case Plan

Wide variations are disclosed in the way the required assessment of the minor mother's situation and the development of a case plan are formulated amongst the 82 counties surveyed. Sixty-seven percent of the counties use the mandated 11-point requirements as a checklist in face-to-face interviews with minor mothers. Thirty percent of the counties devise their own forms,[10] and these vary in both length and detail. A small percent combine methods using a checklist and an open-ended interview. Two assessment forms--used chiefly in urbanized counties--are detailed and lengthy, with more than 50 items to be observed and recorded. Scattered counties use an assessment form developed for public health nurses.

In summary, a wide range of assessment forms are used ranging from a routine checklist to an assessment form designed to lay out specific expectations of behavior with concrete goals and objectives. A few assessment forms include a time frame for completion of tasks outlined in the case plan and explicit follow-up procedures for the county social service worker, along with the collaborative agencies of schools, health, and mental health. (See Appendix 2 for a more detailed account of the variations in assessment forms.)

Almost all counties reported that the assessment is shared with and occasionally signed by the minor mother, implying that the development of the plan is a cooperative enterprise.

Twenty-five percent of the counties suggested that other items should be included in the 11-point assessment: assessing the need for services in chemical dependency, counselling, and family planning was the most frequently mentioned.

The general perception of the social workers is that the 11 points delineated in this legislation have proved useful in the assessment of a case plan.

Sources of Referral and the Discovery of New Cases

According to the counties, a total of 1,755 births to minor mothers have been brought to their attention, since the inception of this legislation. Out of those births to minor mothers, 40% were already active in the agency prior to the 72-hour notice. Those prior active cases (44%) were received from schools, while the mothers were still pregnant, indicating that good communication exists in those counties between the school systems and county social services. Public health staff in medium and small counties also referred a significant number of minor mothers. Small counties, with few minor mothers, depended on informal networks for referral. Generally, public health nurses, the schools, and income maintenance workers were the chief sources of referral.

Referrals from doctors, programs such as WIC, relatives, and self-referrals are relatively small in number.

There are wide variations in criteria for opening a file on every minor for an active, ongoing plan. Five counties interpret the legislation as applying only to minor mothers on AFDC. Almost 60% perceive the legislation as mandating the opening of a file. Less than a third report that they open a file at intake and keep it open, with the intention of keeping it open until the mother reaches the age of 18. A significant number of counties (approximately one-third) reported that they used discretionary judgments following the assessment as to whether the case should be opened for information and referral only, slight service, or referral to child protection.

Of all assessments made, approximately 76% had files created with records of assessment and disposition. Since three-quarters of the counties have computerized systems, the information in these files ise transferred to the computer.

A small percentage of counties report that they open a file only when they are concerned about the "failure to thrive" condition of the infant and when they suspect that there might be a potential referral to child protection. The amount of paperwork in opening a case often leads some counties to use an information and referral or slight services mode which means that they can still explore the need for services without the formal opening of a case that entails a good deal of paperwork.

Typical of reports from counties where a formal case is not opened are the following observations:

> "I'd rather spend time with clients than do reports."
>
> "Our philosophy is to get in and out of a family's life as quickly as possible. The information and referral mode, the slight services mode, crisis counselling don't require lengthy reports, so we often serve clients under these modes."

There does not appear to be a uniform policy or set of criteria for opening a case. Generally, at the front line social service worker level, there is no particular administrative pressure to open or avoid opening a case. However, a small percentage reported that opening a case is counted as "credit" for their Title XX social services accountability.

Case Finding

The rate of referral of minor mothers to child protection varies considerably. Fifty-five counties reported no record of referral of minor mothers to child protection services. Of 17 mid-sized counties, only five cases of 272 cases (approximately 2%) were reported to child protection. A

large major urban county reported that the rate of referral to child protection was 13%. In contrast, of the 300 active cases in another urban county, only six cases, or 2%, were referred to child protection. Overall, it appears that the high risk minor mothers were already known before the legislation was introduced. However, approximately 6% of the cases without a previous contact are referred immediately to protective services.

Nine percent of the cases (approximately 113 minor mothers) are reported as needing long-term supervision. These minor mothers have been identified as high risk for neglect and abuse of the infant, or as having exceptional needs which will prevent them from following through on a plan.

Of the 1,327 open files, only a small number (88 or 7%) are under a "protective payment" sanction. Three percent are excused from compliance with the mandate because of "good cause exception."

Implementation Issues

Troublesome issues in deriving a fair and effective assessment are disclosed. Generally, "hard" services (child care, transportation, etc.) are easier to assess and identify than the subjective judgments on behaviors in relationships and parent and child interactions.

An accurate assessment of the parenting skills of the minor mothers is considered by 70% of social service workers to be the most difficult part of the plan. Almost 80% rely on their judgments from direct observation, while a small number use a formal assessment instrument. Some routinely required attendance at parenting classes.

Deriving an accurate sense of the involvement of the father of the minor's child is also identified as a troublesome issue. In scattered instances, the father was actually present at the time of the assessment.

Making a judgment on the quality of the support system for the minor mother is frequently mentioned as a difficult task, inasmuch as the grandparents' supportive role is often reduced because of disputes with the minor mother over child-rearing practices. Some counties indicat that the non-AFDC minor mother generally has better support networks of family and friends than do AFDC minor mothers.

A small number of minor mothers (almost 9%) are engaged in decision-making groups on adoption. Generally it is reported that peers, family pressures, and attitudes of the minor mothers provide little opportunity for discussing this option.

Long-term economic self-sufficiency is identified as difficult to assess. Judging the "current economic supports" is also identified as troublesome. A significant number of counties report that the AFDC grant is insufficient for basic income. The minor mother's eligibility for AFDC, if she resides with her parents who are "the working poor," is problematic. Frequently, the living arrangements of the minor mothers are difficult to assess, because of a high degree of mobility. Housing is reported as being very expensive for independent living, even when it is the most plausible arrangement.

A number of counties (27%) reported that it is very difficult to maintain the minor mother's interest in completing schooling. In some communities, there are no alternative schools available. For non-AFDC mothers, there are no sanctions for failing to comply with a school plan, compared to clear and punitive sanctions for minor mothers on AFDC. This is regarded by many respondents as unfair.

Community resources are unevenly distributed in the state. Transportation for minor mothers was identified by 57% of the counties as being a major problem. Child care for infants was also described as a formidable barrier, not easily available and extremely expensive.

Problems with runaway minor mothers and their living situations, and the transient relationships of young mothers and their volatile living arrangements are identified as problems. A large measure of uncertainty on how to gauge the overall circumstances is revealed: "Nothing is easy." "Plans change from day to day." "What they say isn't always the truth." "Is living with the minor mother's parents the most appropriate living situation?" "The mother's learning disabilities may, in fact, show up in her parenting skills. She, herself, may have unrealistic expectations of the child."

Eighty percent of the counties reported that in discussing health with the mother, they routinely mention the availability of family planning services, but 20% of the counties avoid any discussion of contraception.

A significant majority, almost 83%, reported that they give the minor mothers the Tennessen Warning, most often in a written statement, although a significant number give the statement and also read it aloud.

Approximately 66% of minor mothers are perceived to need the following services: WIC; family planning; housing; legal aid; counselling.

Involving the Father

In home visit assessments, family members are frequently present. Almost three-quarters of the counties reported that the minor's parents were present, most often the maternal grandmother. The father's presence was occasionally noted.

Although two-thirds of the counties reported that they extend services to the father, a large number of these say they send the offer of services (such as family planning, education planning, and counselling support groups) to the father by way of a message through the mother. More than half make a direct referral to support and collections. One-third say they make no attempt to involve the father. Making an assessment on the father's role in parenting is

regarded as a difficult assignment, not easily observed at first hand, and often described in vague and imprecise ways by the minor mother.

A significant majority (65%) of the counties say they do not assist the mother in signing a Declaration of Parentage. (This is a first stage in paternity adjudication, and provides for the father's name on the birth certificate.) The rest of the counties, in one way or another, indicate that anything having to do with child support and collections and paternity establishment is referred to the IV-D (Child Support Enforcement) office, or they assume that the AFDC financial worker takes care of this. Some believe it is the responsibility of the hospital.

A small number of counties (13) report a referral of the father to parenting classes. A significant number responded that the father is not involved, but they would offer services if he asked for them.

DISCUSSION OF THE FINDINGS

- The social service workers generally approve of this legislation; they find that it clarifies their role and has made their work more effective. But this has a cost. A significant number (35%) believe that the legislation has added a burden to an already overburdened staff. Most of the social service workers who are assigned to implement this mandate already carry several roles within their agencies. They are typically engaged in child protection, foster home placement, custody studies, and responding to families and children in need of services. More than a third of the respondents noted that there really is not enough staff to carry out this legislation in a meaningful way. This accounts for a cursory and somewhat routine assessment, with very little time available to actually establish a relationship with the minor mother that might provide the basis for an

ongoing connection in which the offer of help might be extended and accepted.

- The interviews for the assessment of the minor mother's situation in order to develop a case plan, as directed by the legislation, takes place in what must be regarded as "a honeymoon period," i.e., within a week or two of the birth of the baby. This is a time when the minor mother is typically surrounded by a support network. In this period, problems of living arrangements, economic insufficiencies, and relationship issues have not quite appeared as they probably will in the next few years. The issue of follow-up is particularly relevant if the intent of the legislation is to be carried out. Therefore, why there are such variations in planning for systematic reviews of the case plan is unclear.
- If this legislation has, as one of its intentions, "casefinding," i.e., a preventative intervention orientation, a surprisingly small number of "high risk" minor mothers turn up in this initial assessment. Perhaps the honeymoon period has disguised, for a brief time, problems that might arise later on. One notes, for example, that in a metropolitan county, out of 300 assessments, only 2% (6 cases) were referred to child protection. Note also that 40% of the minor mothers assessed statewide were already known to county human services. Overall, 15% of the cases were judged to be at high risk: to be carried for long-term supervision or referred to child protection. Further, 15% of counties reported that they have been offering these services all along, most often in cooperation with school programs that have active programs for pregnant and parenting teenagers.

- The community, at large, is unaware of this legislation, according to the respondents. The statute is recognized amongst collateral agencies such as schools and public health, but external support for it is minimal because it is not widely known.

PROBLEM AREAS

Among the problem areas uncovered, the following are selected for particular attention.

Follow-up Plans

Follow-up plans, as revealed in the interview data, are loose and often poorly defined. A small portion, 18%, routinely keep the case open until the minor mother turns 18. It is difficult to estimate whether or not this means an active follow-up plan. Systematic and routine follow-up at regular intervals is not a general pattern.

The variations on how case openings are treated reveals the disparities amongst counties in whether to have an "active case" with a follow-up case plan (a small proportion of counties), or whether to treat the case in a "slight service mode," responding only to a request for service. (Most counties use this mode.) Criteria for initiating an active follow-up plan were not easily detected, even though 76% of the referrals became open cases.

The Role of the Social Service Worker

The role of the social service worker is clearly problematical both from the perspective of the social service worker and the point of view of the minor mother. There is uncertainty as to whether the social service worker should present him or herself as "an agent" of the state, carrying out surveillance mandated by a legislative statute; or whether the worker identifies the role as one of advocacy for the minor mother and her child; or

whether the worker is a case manager who scrounges resources. Generally, social service workers prefer to think of themselves as case managers who do all of the above.

The social service workers understand that their presence could be interpreted as "the iron fist in a velvet glove." Most prefer to project themselves in a positive way, as a helping presence, and to play down the role of enforcer. However, a significant number of social service workers were dismayed by the uneasy and fearful response of minor mothers to their presence.

Threaded through the responses was the observation that minor mothers, typically, regard the social service worker as associated with child protection. This is acknowledged as a threatening and intimidating presence. This is reflected in the small number of minor mothers (less than 5%) who are "eager and interested" in participating in the process of developing a case plan.

In summary, the picture is one of minor mothers in reluctant compliance with a requirement that might affect their grant or their rights to their infant. Whether or not the social service worker presents himself or herself as an advocate for the minor mother or an advocate of the system rests with the individual social service worker. County service workers identify this ambiguity (in varying degrees) as a problem in extending services.

DISCRIMINATORY FEATURES

This legislation is directed toward minor mothers who have not yet reached their 18th birthday. Frequently mentioned is the fact that it is the young mother, 18 and older, who is now living independently and often engaged in troubling relationships. This family unit has been identified as truly at high risk.[11] The age factor is considered arbitrary and, for some

respondents, it is believed to single out, unfairly, the younger minor mothers.

The distinction in treatment between the AFDC and non-AFDC populations is also an issue. The county social service workers point out that there is no consequence for non-compliance on a high school plan or for non-participation in the assessment process for the non-AFDC mother, while the AFDC mother has at least two sanctions which may have serious consequences: the protective payment, and/or court-ordered protective supervision. Threaded throughout the comments was the observation that for non-AFDC mothers, there are "no teeth" to assure compliance.[12] It is the financial workers who typically check out school attendance. Non-AFDC minor mothers would not come to their attention.

Another source of discrimination is noted in the fact that minor mothers of working poor families are often ineligible for the basic services of child care and transportation. These are income conditioned, and if the minor mothers are living at home, their parents' earnings may put these indispensable services out of reach.

In a small but distinct number of instances, the legislation was called into question on the grounds that, perhaps, it violated the rights of a minor to privacy.

Respondents noted that a number of non-AFDC families consider this legislation intrusive and a violation of constitutionally protected rights. Particular reference was made to the assumption that minor mothers, as a group, are incompetent, immature, and unable to make decisions on behalf of their infants. Of particular interest in the privacy issue was a question on how long the case was to remain open, and whether the minor mother appears as a "case" in the computerized files even though there is no evidence of non-compliance.

Although the "Tennessen" warning is given, somewhat routinely, there is no evidence that minor mothers clearly understand that this is a protection of their constitutional rights again self-incrimination. Nor was there evidence that a right to appeal the sanction was clearly understood.

Issues dealing with cultural diversity and ethnicity are also raised. Fourteen counties reported outreach difficulties with Native American and migrant minor mothers because of mobility and "unavailability." The interaction with the Indian Child Welfare system is not clear. There appear to be few referrals from that system to county human services. Whether the reverse is true is not well documented. In one or two counties in which there is a high percentage of Native American minor mothers, informal networking between the Indian child welfare system and the county appears to be working effectively.

OTHER PROBLEM AREAS

Border counties identify problems related to interstate mobility of minors mothers. Follow-up has been difficult.

Hospital reports are not always made within the mandated 72 hours following the birth to a minor mother. There appear to be some problems with late and selective reports from hospitals in suburban areas and those in the outlying areas.

The availability of resources for minor mothers, in order for them to complete their case plans, is not uniformly accessible. Services related to chemical dependency, psychiatric counselling, and collateral resources for assessment of parental skills are notably sparse. Child care and transportation are particularly scarce in many parts of the state. Alternative schools options are not uniformly available, and remediation

resources for school failure or special learning problems are also very sparse.

Although a significant number of fathers were reported as being present during home visits, respondents (80%) observed that the fathers were minimally involved with the mothers and children. Outreach to fathers is vague and imprecise, and appears to be a neglected feature in case planning.

How this piece of legislation interacts with requirements under welfare reform is now under discussion. It appears that under this legislation, minor mothers under the age of 18 will be assigned a case manager from the county social services system. Once they turn 18 and up to the age of 20, their case manager will be assigned from the jobs and training system. This disruption in case management may be dysfunctional. At 18 and beyond, the social services needs are inextricably linked to education and job preparation.

Compliance with the school plan may raise problems in arriving at a concensus on when and how sanctions are to be imposed. The financial worker, the social service worker, and the school may have differing views on this, and ways of reconciling their different assessments have not been addressed.

The involvement of the father of the out-of-wedlock child in assessment and case planning is clearly a neglected part of this legislation. His requirement to finish school, and his employment plan, and his living arrrangements are not the focus of any attention. Outreach to fathers is limited. Assistance on paternity issues is routinely referred to the IV-D office (Child Support Enforcement), or it is assumed that the AFDC unit is responsible for this item. Reference to AFDC-UP as a resource for stabilizing the family unit is rarely mentioned.

The extent to which this legislation has any relevance to the small number of minor married mothers is not yet reported. One county reported

puzzlement on how to treat the married minor mothers in this legislative mandate.

The training efforts which reach about half of the county soical service workers are regarded as modestly helpful. Training in assessing parental skills is the most frequently mentioned need.

In summary, efforts to develop a case plan appear to vary widely, from a cursory checklist to a detailed plan that includes behavioral goals and objectives. The amount of time and effort that can be invested in case planning is clearly limited for most county social service workers. Most respondents carry other responsiblities in county human services. As was frequently pointed out, the legislation did not carry an appropriation to augment staff for this particular purpose.

The data are not detailed enough to explicate the question of coordination of services to minor mothers. The size of the county is clearly a factor. In small counties, there is a good deal of informal networking among county social service workers, public health staff, county attorneys, and the school system. With very populous counties and their complex structures, specialization of units appears and there is a loss in informal networking. The coordination between the community social service worker and the staff of work and training units is yet to be spelled out.

EXEMPLARY FEATURES IN IMPLEMENTING THE LEGISLATION

Scattered throughout the survey data is evidence that selected counties have devoted time and energy to a search for solutions to resource problems. Among the efforts, the following are noted: outstanding high school teen-parenting programs; the recruitment of volunteer drivers to assist with transportation; the use of vans for minor mothers that usually provide services for other populations such as the elderly and the disabled; a search

throughout the community for alternative educational plans for the minor mother; consultation with extended family networks to develop a support system; creating self-help support groups; arranging small groups to explore adoption decisions. Thirteen counties refer the father to parenting classes.

A few counties have developed a list of resources for the minor mother, and are preparing brochures that would include basic information on a number of supportive services and community resources. A few counties are sensitive to legal issues and are forging connections to legal resources in the community.

The informal relationships amongst collateral agencies such as schools and public health are in good working order in a number of counties, where the size of the county provides the opportunity for quick, informal exchanges.

RECOMMENDATIONS

- Training in child development and observational skills in assessing parent-child interactions is the most urgent training need.
- Training to clarify the intent of the legislative statute and translating this intent into procedures for case opening and follow-up, with some guidelines, should be initiated.
- Services to increase the involvement of the father with particular reference to the paternity adjudication issue requires focused attention. The assessment should require:
  - -- a way in which the mother can begin to understand the benefits of establishing paternity for her infant;
  - -- the options that are available for establishing paternity;
  - -- outreach plans for meeting directly with the father to assist him with his basic needs for both education and employment;

-- information on procedures for establishing paternity; his rights and responsibilities;

-- arranging for visitation.

- The development of small support groups for minor parents to exchange information, solve mutual problems, and provide a break in the isolation of young, unmarried parents should be encouraged.

The most frequently mentioned request was for the opportunity to have exchanges with county social service staff in the same region. Regularly scheduled peer review opportunities for assessing implementation issues in the legislation should be arranged. Recommendations should be forwarded and responded to by supervisors and administrators.

CONCLUSIONS

How legislative efforts affect the lives of children is truly the history of child welfare. This legislation belongs to that honorable history: it is intended to provide new ways of ensuring the optimum growth and development of children and also to provide opportunities for the minor mother. Regrettably, less attention is paid to the father.

Have the findings on the first year of implementation of the statute satisfied the intent of the legislature in its pursuit of a preventative strategy? It is too early to say that the assumed negative consequences of minor parenting have been reduced. What this survey provides is an identification of issues to be explored and base data from which to do follow-up.

The availability of good social support networks and access to services does increase chances for success of young parents and their children. Whether the compulsory features of this legislation with associated sanctions rather than voluntary participation in case planning provides the most

effective strategy is unknown, at this point. This survey indirectly exposed the fear and intimidation associated with social service workers who are representatives of the county. The connection is made by minor mothers, mistakenly perhaps, that county workers are, in fact, covert agents of child protection. This is not a favorable milieu for a helping relationship.

As one respondent noted, the grudging compliance of a great many of the minor mothers to this legislation masks the fact that they are "frozen in fear" of the authority that is carried by the county social service worker. Hovering over the visit is the fear that, at any moment, child protection can be called in. This perception, in many ways, prevents "the offer of services," which might, in fact, be the most useful way to proceed.

The authority invested in the county social service worker is formidable. Sanctions for failure to follow the steps in a case plan are intimidating. The law does provide the state the right to investigate, to mandate a set of behaviors, and if compliance is not forthcoming, to punish. Most social service workers try to generate a helping presence within this framework. They are, as a group, sensitive to the fact that they are carrying a big stick. Indeed, very few resort to a court order for initiating protective supervision. However, a significant number of social service workers are frank to acknowledge the difficulties of establishing a trusting relationship in a milieu that is perceived as coercive by the minor mother.

Something more than an assessment and a case plan is needed to create a change for an optimum set of circumstances for a teenage mother's life. It requires, most often, a relationship of a helping kind that is perceived as useful and nonintrusive, respecting the autonomy and privacy that should be accorded to these maturing adolescents. Whether or not the mandated requirements in this legislation provide this environment is an open question.

A survey of the attitudes of minor themselves to this legislation would certainly provide insights on this important issue.

The legislation appears to be based on an assumption that minor mothers, as a group, do not have adequate foresight concerning what is best for themselves and their children; that they will make poor choices that perpetuate poverty and failure. If social services and support networks can have an effect, our data is somewhat reassuring on this point. It appears that school systems have, throughout the state, by and large, responded with supportive programs for pregnant teenagers, and with some attempt at follow-up. When infants are born, a significant number of minor mothers (40%) were already known and connected to a county social and service network.

Whether this legislation can reach "the high school dropout," in a significant way, is yet to be disclosed.

Whether the legislation is perceived as helpful or punitive by the minor mothers is the key to sustained follow-up procedures.

Generally, county social service workers are sensitive to the rights of minor mothers they are required to help. However, this law, in testing a preventive strategy, plunges the state into the complex and perplexing arena of balancing the right of the state to intervene on behalf of the best interests of the minor mother and her child and the right of minor mothers to protect their privacy until harm has been demonstrated. Does this law interfere unnecessarily in the lives of minor parents? This question is yet to be tested.

What this survey provides is an identification of issues to be explored and base data from which to do follow-up. The extent to which this legislation works to enhance the life chances for minor mothers and their children is yet to be studied.

Addendum

Recent welfare reform legislation embodied in the federal Family Support Act of 1988 (see Title II, Section 201) creates complications for the Minnesota case plan mandate for minor mothers.

As of July 1989, the federal Family Suppoort Act requires minor mothers 18 and under to attend a secondary school to complete high school education in order to receive AFDC benefits. Failure to comply will result in a grant reduction. This replaces the sanction in the Minnesota Statute of a protective or vendored payment for non-compliance with an educational plan.

However, the Minnesota Statutes requiring a sanction on non-compliance with a social service plan still remains in force, i.e., a vendored payment may be ordered if satisfactory progress toward a social service plan is not completed.

For minor mothers 18 and 19 who have not reached their 20th birthday, the federal law imposes a reduction in the grant for those who fail to make "good progress" academically in reaching their high school completion.

FOOTNOTES

[1]Amended Minnesota Statutes, 1986, Section 257.33, Subdivision 2.

[2]Instructional Bulletin #87-68G, July 20, 1987, State of Minnesota, Department of Human Services. For the legal reference, see M.S. 1988, Section 257.33.

[3]"Good cause," as defined by the AFDC statute, could include parent illness, child illness, only available school programs requiring more than two hours in travel time, lack of availability of child care, lack of availability of appropriate educational programs, child medical appointments, court appearances, physician's certification of need for parent to remain at home with a very young child.

[4]Minnesota Statutes, 1986, Section 260.155, amended: A bill for an act relating to children; providing for protective supervision of children who are dependent because of the minority of a parent; amending Minnesota Statutes 1986, section 260.015; subdivision 6; 260.155, by adding a subdivision; and 260.191, by adding a subdivision.

[5]This applies only to minor mothers on the AFDC grant. The AFDC grant is removed from the minor mother and placed in the hands of a third party. The "protective payment" is sometimes known as a "vendored payment."

[6]Paul Farseth and Joel Kvamme, Longitudinal Studies of Minnesota AFDC Case Duration: Early Results from a Second Multi-year Study, Minnesota Department of Human Services, July 1989.

[7]Telephone conversation with Senator Linda Berglin, October 24, 1989.

[8]Memo from Michael Scandrett, Senate Counsel, on "Teenage Parents: A Non-Welfare Method of Mandating High School Attendance and Social Service Involvement," February 10, 1987.

[9]1987, chapter 403, article 3, subdivision 44, known as the Welfare Reform Package.

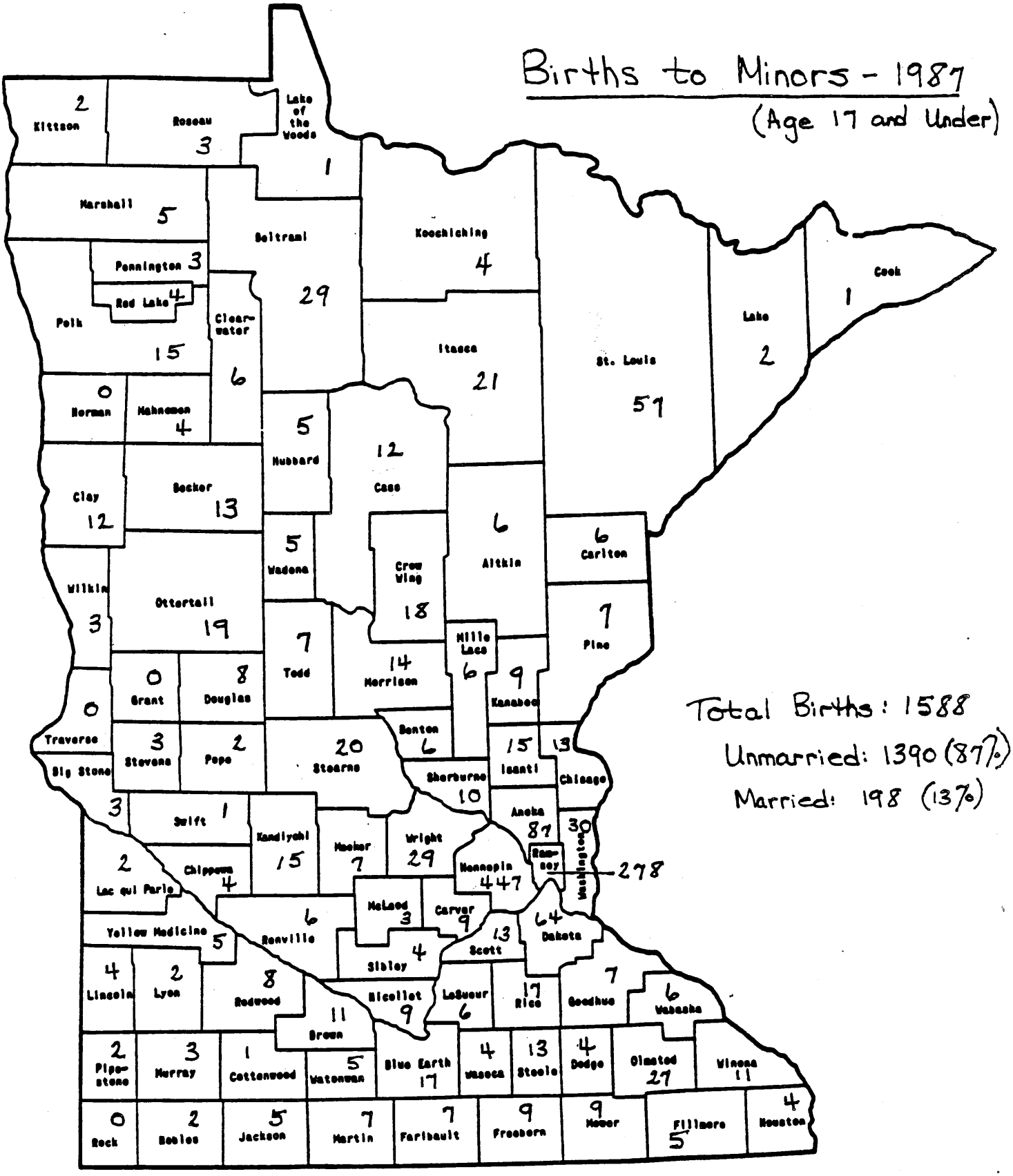
[10]Some forms are simple expansions of the 11-points in the legislation. One metropolitan county uses an 8-page assessment form. Forms developed by maternal and child health practitioners are also used. In one county, the public health nurse conducts the assessment.

[11]Confirming this impression one notes that data from the 1986 child maltreatment reports from the Minnesota Department of Human Services reveal that only 4% of 15-16 year old minor mothers are identified as perpetrators in maltreatment incidents compared to 16% of 19 and 20 year old mothers. "Special Report of the Research and Planning Section," Community Services Division, prepared by David Berry, October, 1989.

[12]The sanctions are income conditioned for those receiving an AFDC grant. However, when there is evidence of abuse and neglect, the case is referred to child protection, and this refers to all minor mothers.

APPENDIX I

DPW-448
(9-71)



Source: Minnesota Department of Health, Center for Health Statistics

APPENDIX II

ASSESSMENT FORMS USED BY COUNTIES*

MANDATORY CASE PLANNING FOR MINNESOTA
MINOR MOTHERS AND THEIR CHILDREN

Prepared by Mary Ford

Expansion of 11 point plan:

Nine counties created assessment forms based on the 11 point plan. On these forms space was allowed for the social worker to write down his/her observations and comments. Three of the nine counties (which coordinate services in a tri-county fashion) created a form from the 11 points plus they added an "Expected Time Frame of Completion," and "Frequency of Social Worker Contact" which implies ongoing contact between social worker and minor mother. Four of the nine counties were in the 19,872 - 29,936 (medium-small) population range. Four of nine counties were located in central Minnesota.

Other forms designed by counties:

One medium-small sized, sub-metro county created a highly structured assessment form which included concrete goals and objectives for the minor mother for each of the 11 points. It did not appear that there was room for individualized goals, and social worker goals and participation were not mentioned. However, expectations for the minor mother were clearly spelled out, and the form included sytematic contact between the county social worker and collaborative contacts, such as school counselors and public health nurse, for the purpose of evaluating the minor mother. The plan included follow-up at six month intervals, but did not mention frequency of contact between social worker and minor mother.

A small county located in southwestern Minnesota sent an assessment form which looked like a child protection assessment form. A "problems" and "assets" checklist covered health, housing, income, social relationships, and other areas. The form seemed to be based on a "client pathology model."

A small county in western Minnesota created an interesting form, part of which appeared to be designed for the minor mother to fill out on her own (a good method of low-key confrontation and a way to create "cognitive dissonance" in the mother, for example, around the reality of keeping the baby or placing).

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*Sixteen counties sent their minor mother assessment forms. The forms ranged from simple expansions of the 11 points in the legislation to an eight-page assessment used by a metropolitan county, to a public health nurse assessment form.

Another part of the form evaluated the minor mother's level of autonomy in decision making, her support system, her occupational goals and how she envisioned attaining those goals, and her present condition and her ability to project future conditions. The form even had a page for the minor mother to draw herself as she sees herself now, and in the future. It seemed to be a form created by a really good social worker to be used by social workers without a lot of training or assessment skills.

Another small, western Minnesota county sent the AAPI (Adult - Adolescent Parenting Inventory) which that county uses to help assess minor mothers. The minor answers questions about parenting and raising children on a continuum from strongly agree to strongly disagree.

Two of the largest metro counties use detailed assessment forms; one is a three page social worker's "checklist," and the other is an eight page form. The three page form assesses pre-natal care, continuity of living arrangement, relationship with the baby's father, and other questions which are an expansion of the 11 point plan. the eight page form is also a social worker's "checklist" and includes very detailed questions pertaining to the 11 point plan, plus extensive questioning about the emotional and behavioral qualities of the mother.

A medium sized county in south central Minnesota employs a public health nurse to do the minor mother assessment; thus the nurse uses a health assessment form plus assessment of the infants' developmental progress and alertness. She also uses the 11 point plan from the mandated assessment, but stated that she did not feel competent to accurately assess many of those areas. The public health nurse in this county saw herself as being less threatening to the minor mother than a "social worker,' but the services the minor mother needed were inevitably social services which the PH nurse was unable to provide, and referral to those services was often clumsy.